Disability Retirement Election Application

888 CalPERS (or **888**-225-7377) • TTY for Speech and Hearing Impaired: (916) 795-3240

Employer Information

☐ Check if this is an employer-originated application.
Employer must fill out and sign Section 12 on the last page of this application.

Application Type

☐ Disability Retirement
☐ Service Pending Disability Retirement
☐ Industrial Disablility Retirement
☐ Service Pending Industrial Disability Retirement

Section 1 — Information About You

Please provide your name as it appears on the Social Security card.

Display all dates in this order: month/day/year.

Name of Member (First Name, Middle Initial, Last Name) | Social Security Number (– –)

Address

City | State | ZIP | Country

Birthdate (mm/dd/yyyy) | ☐ Male ☐ Female Gender | ( ) Home Phone | ( ) Work Phone

Section 2 — Retirement Information

Please do not abbreviate your employer or position.

Do not list Social Security, military or railroad retirement as a California public retirement system.

Retirement Date (mm/dd/yyyy)

Employer | Position Title

Do you have any final compensation period higher than the last consecutive 12 or 36 months?
☐ No ☐ Yes, from _____ (Beginning Date (mm/dd/yyyy)) to _____ (Ending Date (mm/dd/yyyy)).

Are you a member of a California public retirement system other than CalPERS? ☐ No ☐ Yes, provide:

Name of System

Date of Retirement (mm/dd/yyyy) | Beginning Service Credit Date (mm/dd/yyyy) | Ending Service Credit Date (mm/dd/yyyy)

Section 3 — Workers' Compensation Information

Local safety members should not complete Sections 3 & 4.

Workers' Compensation Carrier

Name of Adjuster | ( ) Phone Number

Address

City | State | ZIP

Claim Number(s) Relating to Alleged Disability | Date of Injury (mm/dd/yyyy)

Put your name and Social Security number at the top of every page.

Your Name | **Social Security Number** _ _

Section 4

Please complete all the questions below. If you need additional space, attach separate sheets and be sure to include your name and Social Security number on all sheets.

Disability Information

What is your specific disability; when and how did it occur?

What is the complete name and address of your treating physician(s)?

Name of Treating Physician | Medical Record Number

Address

City | State | ZIP | ( ) Phone Number

What are your limitations/preclusions due to your injury or illness?

How has your injury or illness affected your ability to perform your job?

Are you currently working in any capacity (full-time, part-time, or modified work)? If yes, please explain.

Other information you would like to provide.

Did a third party cause your injury? ☐ No ☐ Yes (If yes, CalPERS has a potential "right of subrogation.")

Put your name and Social Security number at the top of every page.

Your Name _____ Social Security Number _ _ _

Section 5

Select Your Retirement Payment Option and Beneficiary

Select **only one** payment option: Option 1, Option 2, Option 2W, Option 3, Option 3W, the Unmodified Allowance Option, or one of the Option 4 types.

By filling out this section, you are electing your Retirement Payment Option and designating your beneficiary. Once you select a payment option, you cannot change to another option. Along with your option selection, you must complete at least one of the beneficiary designations in Sections 5a-5d. If you choose the Unmodified Allowance Option, you do not need to specify a beneficiary. Please see pages 18 to 22 for more information on this section.

☐ **Option 1** - To complete this option choice, you must also fill out Section 5d, *Balance of Contributions Beneficiary(ies).*

☐ **Option 2** - To complete this option choice, you must also fill out Section 5a, *Individual Lifetime Beneficiary*.

☐ **Option 2W** - To complete this option choice, you must also fill out Section 5a, *Individual Lifetime Beneficiary*.

☐ **Option 3** - To complete this option choice, you must also fill out Section 5a, *Individual Lifetime Beneficiary*.

☐ **Option 3W** - To complete this option choice, you must also fill out Section 5a, *Individual Lifetime Beneficiary*.

☐ **Unmodified Allowance Option** - If you select this option there is no return of your member contributions and no monthly benefits payable upon your death - except the Survivor Continuance benefit, if applicable. There is no beneficiary designation for this option.

These options apply to Option 4 **Individual Lifetime Beneficiary** only.

☐ **Option 4, Individual Lifetime Beneficiary** - If you select this option, you must also select one of the following Individual Lifetime Beneficiary options below.

- ☐ **Option 2W & Option 1** Combined - To complete this option choice, you must also fill out Section 5a *Individual Lifetime Beneficiary* and Section 5d *Balance of Contributions Beneficiary(ies).*
- ☐ **Option 3W & Option 1 Combined** - To complete this option choice, you must also fill out Section 5a *Individual Lifetime Beneficiary* and Section 5d *Balance of Contributions Beneficiary(ies).*
- ☐ **Specific Dollar Amount to Beneficiary** $_____ (Dollars) - To complete this option choice, you must also fill out Section 5a *Individual Lifetime Beneficiary*
- ☐ **Specific Percentage to Beneficiary** _____ (Percent)% - To complete this option choice, you must also fill out Section 5a *Individual Lifetime Beneficiary*
- ☐ **Reduced Allowance for Fixed Period of Time** _____ (Percent or Dollars) **through** _____ (Date (mm/yyyy)).
- ☐ **Reduced Allowance upon death of retiree or beneficiary:** $_____ (Dollars) **reduction amount**

  If you are naming a beneficiary under this option, you must also fill out Section 5a, *Individual Lifetime Beneficiary*.

☐ **Option 4, Multiple Lifetime Beneficiaries** - To complete this option choice, you must also fill out Section 5b *Option 4 Multiple Lifetime Beneficiaries.*

This option applies to Option 4 **Multiple Lifetime Beneficiaries** only.

☐ **Option 4, Court Ordered Community Property** - If you select this option, you must also complete Section 5c, *Court Ordered C.P. Beneficiary* and select one of the following Court Ordered Option 4 Community Property options.

These options apply to Option 4, **Court Ordered Community Property** only.

- ☐ **Option 4/Unmodified** - There is no additional beneficiary designation for this option.
- ☐ **Option 4/1** - To complete this option choice, you must also fill out Section 5d, *Balance of Contributions Beneficiary(ies).*
- ☐ **Option 4/2W** - To complete this option, you must also fill out Section 5a, *Individual Lifetime Beneficiary*.
- ☐ **Option 4/3W** - To complete this option, you must also fill out Section 5a, *Individual Lifetime Beneficiary*.

Put your name and Social Security number at the top of every page.

Your Name | **Social Security Number**

Section 5a

Option 2, 2W, 3, 3W or 4 Individual Lifetime Beneficiary

Designate one beneficiary and provide all of that person's information including full name.

Complete this section only if you chose either Option 2, 2W, 3, 3W or Option 4 Individual Lifetime Beneficiary or Option 4/2W or 4/3W Court Ordered Community Property.

Name (First Name, Middle Initial, Last Name) | Social Security Number

Birthdate (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You

Address

City | State | ZIP | Country

Section 5b

Option 4 Multiple Lifetime Beneficiaries

If you want your beneficiaries to receive an equal share of your benefits, do **not** specify a dollar or percentage of benefit.

Complete this section **only** if you selected **Option 4 Multiple Lifetime Beneficiaries**.

Name (First Name, Middle Initial, Last Name) | Social Security Number

Birthdate (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You | Dollar/Percent of Benefit

Address

City | State | ZIP | Country

Name (First Name, Middle Initial, Last Name) | Social Security Number

Birthdate (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You | Dollar/Percent of Benefit

Address

City | State | ZIP | Country

Name (First Name, Middle Initial, Last Name) | Social Security Number

Birthdate (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You | Dollar/Percent of Benefit

Address

City | State | ZIP | Country

Section 5c

Court Ordered Option 4 Community Property Beneficiary

List **only** the Option 4 beneficiary that is required by your court order.

Complete this section **only** if you selected **Option 4 Court Ordered Community Property**.

Name (First Name, Middle Initial, Last Name) | Social Security Number

Birthdate (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You

Address

City | State | ZIP | Country

Put your name and Social Security number at the top of every page.

Your Name | **Social Security Number** (___ ___)

Section 5d

Option 1 Balance of Contributions Beneficiary(ies)

Designate up to three beneficiaries here. If you want to designate more than three beneficiaries. See page 23 for information on completing the Lump Sum Beneficiary Designation form.

Complete this section only if you selected **Option 1**, **Option 4-2W/1** or **3W/1 combined**. You may change this beneficiary(ies) at any time. This designation automatically revokes when there is a change in your marital status, domestic partnership status, or when there is a birth or adoption of a child. For detailed information and instructions please refer to pages 23 and 24 of this booklet.

Name (First Name, Middle Initial, Last Name) | Social Security Number (___ ___)

Birthdate (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You

Address

City | State | ZIP | Country

Name (First Name, Middle Initial, Last Name) | Social Security Number (___ ___)

Birthdate (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You

Address

City | State | ZIP | Country

Name (First Name, Middle Initial, Last Name) | Social Security Number (___ ___)

Birthdate (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You

Address

City | State | ZIP | Country

Section 6

Retired Death Benefit

All Applicants must complete this section.

Designate your beneficiary to receive your lump sum Retired Death Benefit.

This section designates the person who will receive your lump sum Retired Death Benefit. You may change this beneficiary(ies) at any time. This designation automatically revokes when there is a change in your marital status, domestic partnership status, or when there is a birth or adoption of a child. For detailed information and instructions please refer to page 24 of this booklet.

Name (First Name, Middle Initial, Last Name) | Social Security Number (___ ___)

Birthdate (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You

Address

City | State | ZIP | Country

Section 6 continues on page 6

Put your name and Social Security number at the top of every page.

Your Name _____ Social Security Number _____

Section 6, continued — Retired Death Benefit

All Applicants must complete this section.

Designate your beneficiary to receive your lump sum Retired Death Benefit.

Name (First Name, Middle Initial, Last Name) _____ Social Security Number _____

Birthdate (mm/dd/yyyy) _____ ☐ Male ☐ Female Gender _____ Relationship to You _____

Address _____

City _____ State _____ ZIP _____ Country _____

Name (First Name, Middle Initial, Last Name) _____ Social Security Number _____

Birthdate (mm/dd/yyyy) _____ ☐ Male ☐ Female Gender _____ Relationship to You _____

Address _____

City _____ State _____ ZIP _____ Country _____

Section 7 — Survivor Continuance

Please answer all five questions and complete the information in each section where you answered "Yes."

Please see pages 24 and 25 for more information on this section.

1. Will you be married on, and at least one year prior to, your retirement date? ☐ No ☐ Yes, provide:

Name of Spouse (First Name, Middle Initial, Last Name) _____ Social Security Number _____

Birthdate (mm/dd/yyyy) _____ ☐ Male ☐ Female Gender _____ Date of Marriage _____

2. Will you be registered with the California Secretary of State as being in a domestic partnership on and at least one year prior to your retirement date? ☐ No ☐ Yes, provide:

Name of Domestic Partner (First Name, Middle Initial, Last Name) _____ Social Security Number _____

Birthdate (mm/dd/yyyy) _____ ☐ Male ☐ Female Gender _____ Date of Registered Partnership (mm/dd/yyy) _____

3. Do you have any natural or adopted children under age 18 who have never been married? ☐ No ☐ Yes, provide:

Name of Child (First Name, Middle Initial, Last Name) _____ Social Security Number _____ Birthdate (mm/dd/yyyy) _____

Name of Child (First Name, Middle Initial, Last Name) _____ Social Security Number _____ Birthdate (mm/dd/yyyy) _____

4. Do you have any children who have never been married and were disabled prior to their 18th birthday and who are still disabled? ☐ No ☐ Yes, provide:

Name of Child (First Name, Middle Initial, Last Name) _____ Social Security Number _____ Birthdate (mm/dd/yyyy) _____

Name of Child (First Name, Middle Initial, Last Name) _____ Social Security Number _____ Birthdate (mm/dd/yyyy) _____

5. Are your parents dependent upon you for one-half of their support? ☐ No ☐ Yes, provide:

Name of Parent (First Name, Middle Initial, Last Name) _____ Social Security Number _____ Birthdate (mm/dd/yyyy) _____

Name of Parent (First Name, Middle Initial, Last Name) _____ Social Security Number _____ Birthdate (mm/dd/yyyy) _____

Put your name and Social Security number at the top of every page.

Your Name _____ Social Security Number _ _ _

Section 8 Last Day on Payroll

Please enter the last day you received compensation. _____
Last Day on Payroll (mm/dd/yyyy)

Section 9 Employer Certification (For service pending applications only)

Have your employer complete this section.

Do not detach from application.

This certification is not required if you were separated from employment more than four months ago.

Please see page 25 for more information on this section.

Employee's Last Day on Payroll (mm/dd/yyyy) _____ Employee's Separation Date (mm/dd/yyyy) _____

Balance of unused sick leave hours on employee's date of separation _____ Hours ÷ 8 = _____ Days

Balance of educational leave hours on employee's date of separation _____ Hours ÷ 8 = _____ Days

By signing below, you hereby certify, under the penalty of perjury, that the above information is true, complete, and correct to the best of your knowledge. Any changes to this information must be submitted on an Amended Employer Certification form.

Signature of Employer _____ Print Name (First Name, Middle Initial, Last Name) _____

Position Title of Employer _____ Phone Number of Employer ( ) _____ Date (mm/dd/yyyy) _____

Section 10 Tax Withholding Election

Do not complete for industrial disabilty retirement.

Please choose one only.

Federal Income Tax information. Please see page 26 for more information on this section.

☐ Do not withhold federal income tax.

☐ Withhold federal income tax in the amount of $_____ Dollars per month.

☐ Withhold federal income tax based on the tax tables for:

- ☐ **A married individual with _____ Number tax withholding exemptions.**
- ☐ **A single individual with _____ Number tax withholding exemptions.**

In addition to the amount withheld based on the tax tables, withhold $_____ Dollars per month.

State withholding is optional for out-of-state residents.

State Income Tax information. Please see page 26 for more information on this section.

☐ Do not withhold State of California income tax.

☐ Withhold State of California income tax in the amount of $_____ Dollars per month.

☐ Withhold State of California income tax based on the tax tables for:

- ☐ **A married individual with _____ Number tax withholding exemptions.**
- ☐ **A single individual with _____ Number tax withholding exemptions.**

In addition to the amount withheld based on the tax tables, withhold $_____ Dollars per month.

☐ Withhold State of California income tax in the amount of 10 percent of the federal income tax withholding amount.

Put your name and Social Security number at the top of every page.

Your Name | Social Security Number

Section 11

Member Signature and Notary

This section must be completed or your application will be returned.

If your spouse's or domestic partner's signature is not available, see page 30 for instructions on completing the Justification for Absence of Signature form.

Your signature and your spouse's or domestic partner's signature must be notarized by a notary public or witnessed by a CalPERS representative.

I certify, under the penalty of perjury, that the information submitted hereon is true and correct to the best of my knowledge. I understand that to cancel this application I must notify CalPERS before the mailing of my first full monthly retirement allowance check.

I understand that if I am married or in a registered domestic partnership, but do not name my spouse or partner as beneficiary, they may still be entitled to a community property share of the Option 1 lump sum return of contributions benefit OR a share of the monthly option death benefit allowance. Their community property interest is 50 percent of the benefit based on the contributions or service credit earned for the period of CalPERS service during which we were married or in a registered partnership. My non-spouse or non-partner designated beneficiary will receive the portion of the lump sum Option 1 benefit or monthly option allowance that is **not** payable to my spouse or domestic partner. I understand that my spouse or domestic partner will have the right to disclaim entitlement to their community property interest in the death benefit at the time the benefit becomes payable, if they so desire.

See page 26 for more information on this section.

Are you legally married or do you have a legal domestic partner? ☐ Yes ☐ No

If yes, your spouse or domestic partner must sign this election.

If no, please indicate: ☐ Never Married/or in Partnership ☐ Divorced/Annulled or Termination ☐ Widowed of Domestic Partnership

Signature of Member | Date (mm/dd/yyyy)

Signature of Spouse or Domestic Partner | Date (mm/dd/yyyy)

State of California, County of _____ On _____ before me,

_____ personally appeared _____,
name and title of the officer

personally known to me (or proved to me on the basis of satisfactory evidence) to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

Witness my hand and official seal or authorized CalPERS representative signature.

Signature of Notary or CalPERS Representative | Position Title | Date (mm/dd/yyyy)

Print Name | CalPERS Office (if applicable)

If this is an employer originated application, employer must fill out Section 12.

Section 12

Employer-Originated Applications

To be completed if the employer is submitting the application on behalf of the member.

Signature of Employer

Print Name of Employer

Position Title of Employer | ( ) Phone Number | Date (mm/dd/yyyy)

Mail to: **CalPERS Benefit Services Division** • P.O. Box 942711, Sacramento, California 94229-2711